DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11083 (03/05)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA)

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) Completion Instructions (HCF 11083A).

Prescribers are required to submit this completed form to the dispensing provider where the prescription will be filled.

Dispensing providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name
5. Strength(s)
6. National Drug Code (NDC)
7. Date Prescription Written
8. Directions for Use
9. Start Date Requested
10. Diagnosis — Primary Code and / or Description
11. Name — Prescriber
12. Drug Enforcement Agency Number
13. Address — Prescriber (Street, City, State, Zip Code)
14. Telephone Number — Prescriber
15. Is “Brand Medically Necessary” handwritten by the prescriber on the prescription? ❑ Yes ❑ No

SECTION III — CLINICAL INFORMATION

16. Has the recipient experienced an adverse reaction to the generic drug? ❑ Yes ❑ No
    If yes, indicate the adverse reaction that can be directly attributed to the generic drug in the space provided.
17. Has the recipient experienced an allergic reaction to the generic drug? ❑ Yes ❑ No
    If yes, indicate the allergic reaction in the space provided.
18. Has the recipient experienced an actual therapeutic failure of the generic drug? ❑ Yes ❑ No
    If yes, indicate the actual therapeutic failure in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

19. For the following drugs only: Clozaril, Coumadin, Dilantin, Neoral, or Tegretol
Is there an anticipated therapeutic failure of the generic drug? ❑ Yes ❑ No
If yes, indicate the anticipated failure in the space provided.

20. SIGNATURE — Prescriber	21. Date Signed

SECTION IV — ADDITIONAL INFORMATION

22. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.

Reset Form